Testimony Before the State Senate Committee on Health
Regarding Housing and Services for People with Mental Illnesses
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Good morning, Madam Chair and members of the State Senate Committee on Health, Children, Families, Aging and Long-Term Care. My name is Jim Hill. I am the Administrator of the Milwaukee County Behavioral Health Division. For the record, my Division is responsible for the oversight and delivery of a wide range of state-mandated treatment and support services for persons experiencing mental illnesses, substance abuse and developmental disabilities in Milwaukee County. We are the largest public mental health system in the state.

I thank you for the invitation to again address this Committee on the work we have done and continue to do to meet the housing needs of the people we serve.

I want to tell you that since April of this year, when we last met to discuss these issues, every person with a serious mental illness in Milwaukee County who is also poor, unable to work due to his illness, and without a permanent home has been rescued from the squalor to which their condition often consigns them. But right now I can't.

I want to announce today that a grand coalition of private developers, community advocates, elected officials and government bureaucrats has agreed to undertake the production of 10,000 units of decent, safe and affordable housing for these individuals, and that these units will be available for occupancy before winter settles over the city. But right now I can't say that.

I want to tell you that a comprehensive community education effort has all but eradicated the stigma commonly and unjustly associated with mental illness, and that it has also wiped out the "NIMBY" mindset that invariably follows it around, and that as a result of all this, neighborhoods in every part of Milwaukee County – from the sprawling landscaped tracts of the wealthiest suburbs to the dense and aging enclaves of the central city – all welcome those who desire safe, clean, affordable housing, no matter their illness. But right now I can't.

Still, this is my vision and my hope. It is, I believe, the vision and hope of every caring human being. For the sake of those victimized by the scourges of poverty, bigotry, prejudice, and mental illness, it is a vision and hope that must not be abandoned.

But it is also a vision that will not appear simply because we summon it, or with a single, instantaneous sweeping of the hand, or because a journalist writes articles that periodically remind us that we're not quite there. And it is a vision that cannot, will not – and, some would argue, *should* not – be realized through the actions of a single government bureaucracy with numerous mandates and insufficient resources doing what it can to address the critical treatment needs of people with mental illnesses.

The causes contributing to the abject conditions in which all too many people with mental illnesses are relegated are found in history, medicine, law and economics. The interactions of these causes are multi-layered and complex. Their roots are buried deep in the soil of many generations and are wrapped tightly around some of the most toxic and intractable human attitudes, namely bigotry, ignorance and stigma. The lack of safe, affordable and decent housing for people in poverty, whether they suffer from mental illnesses or not, is but one of the manifestations of this legacy.

This vision will take shape when the community resolves and acts to replace neglect, injustice and indifference with respect, justice and compassion; when its members resolve and act to permanently disable the social, economic and attitudinal forces that consign groups of vulnerable human beings to its margins; and when it begins to shoulder the difficult, expensive and sometimes uncomfortable work that will be demanded of it.

In the real world, this vision is being built meeting by meeting, conversation by conversation, step by step. This is not the stuff of "grab-you-by-the-throat" journalism, but it is the essential prerequisite to meeting the challenges we face every day. When viewed and understood in this context, there is much to report. Within our mandate and the resources available to us:

- BHD has created a housing committee to include various community agencies in the mental health and AODA networks to identify the specialized housing needs of our clients. The committee meets regularly. It is charged with the task, among other things, of providing advice to BHD staff concerning areas of need for housing, and has begun discussions with community groups regarding opportunities for new affordable housing development.

- The BHD Shelter Plus Care grant, which is similar to section 8 where clients pay approximately 30% of their income towards rent, continues to provide permanent housing to 300 individuals each year who have been homeless and are disabled. All units pass a Housing Quality Standards inspection prior to the client moving in.

- BHD administers the Housing Organization and Direct Assistance Program (HODAP). This grant provides individuals in our mental health case management network as well as in the WIser Choice system with security deposit and rent assistance in an effort to improve the client's housing situation. All units must pass a Housing Quality Standards inspection.

- BHD administers the Safe Haven grant, which provides a soft entry point for homeless individuals who suffer from mental illness. These individuals have previously not been engaged in mental health treatment. Safe Havens allow the clients to be connected to case management in an effort to move to more permanent housing.

- With the participation of the BHD Housing Coordinator and housing committee, I have been discussing new construction of low-income housing with interested developers. These developers, both local and regional, have begun working with our housing committee to identify strategies to expand available housing to these clients, to identify facilities that may lend themselves to redevelopment as housing, and to identify what external assistance if any is needed to implement these strategies. With these partners, we are exploring and will pursue all feasible affordable housing development initiatives and funding sources.

- BHD is building a formal network of housing providers through our WIser Choice grant program. As the network expands, all prospective housing providers will need to apply for inclusion in the network and all units will be inspected for quality if they expect to be able to serve all BHD clients, whether they have mental health or substance abuse issues, or both.

- BHD has continuously built a substantial *in*formal network of housing providers for our mental health consumers, ranging from independent landlords, room and boards, and other supported housing. The housing provid-

ers in this informal network will be expected to apply for inclusion in the housing network being set up and implemented (above) in order to receive receives BHD clients and funding. The BHD Housing Coordinator personally visits these properties to assess their suitability for our clients, and to the greatest possible extent (given that we are not a housing authority or building inspection agency), we try to stay on top of these providers to make sure they maintain their housing in livable condition.

- Immediately following the last hearing by this body, BHD called together representatives of all case management agencies under contract with the county to address the specific examples of unsafe and unsanitary living conditions cited in the series; to hear from the case management agencies about the extent of the problem beyond what was cited in the series; to identify clients of BHD who may have been living in the housing units described in the articles; and to begin at once to offer assistance to those wishing to find a cleaner, safer place to live. We also requested that agencies' case managers build their networks through personal visits and conversations with landlords about what our consumers need and what we expect in terms of the quality of their housing.

- BHD and agency case management staff offered relocation assistance to 15 individuals who were known to be living in the substandard properties identified in Ms. Kissinger's articles. Six consumers accepted our help and were relocated; three individuals declined our assistance, as is their right to do. Several, as expected, have been more difficult to assist in relocating due to a troubling history of property damage, fire-starting or other problematic behaviors. Even so, our efforts to assist them continue.

- BHD and agency case management staff requested and received a briefing from state Department of Health and Family Services staff regarding standards and criteria used in the licensing of group homes. This information will assist case managers in identifying facilities attempting to operate as group home without proper licensing.

- BHD staff met with representatives of the city Department of Neighborhood Services to gain a better understanding of what the department is and isn't able to do regarding housing licensing and inspection authority. The

meeting resulted in an agreement between us to work closely together to identify substandard housing units in the community and to provide case managers with easier access to information about licensing and zoning of specific properties. Information we have learned from that discussion has been shared with case management staff.

- As Ms. Santala has reported, BHD staff have more recently met with representatives of her division, the Wisconsin Housing and Economic Development Authority (WHEDA) and the state Department of Commerce to give some specificity to the scope of the need for safe and affordable low-income housing in Milwaukee County, to pinpoint the bureaucratic impediments to meeting this need, and to propose the next steps in the plan to realize this vision.

- Later this month, I and my staff will be meeting with the City of Milwaukee Housing Authority Director and his staff, along with the city's community development block grant staff, to identify the specific roles the housing authority and CDBG funds can play in addressing the housing needs of poor people with mental illnesses, and to determine what can and should be done next. It has been a very long time since a discussion of this scope and content has taken place. I believe the possibilities here are considerable and exciting.

That almost no mention of these activities and initiatives has been made in either Ms. Kissinger's original series or in her follow-up article published just a few days ago is, I confess, a source of frustration for me. But, it comes with the territory.

My larger concerns with these omissions, which have now been underscored in today's Milwaukee Journal-Sentinel editorial, are not so easily dismissed, however; and I cannot continue to permit the inaccurate impressions they leave to go unchallenged. Articles that repeatedly re-document conditions of squalor that no compassionate human being accepts with no acknowledgment, nevermind a cogent analysis, of the root causes of those conditions leave readers with the perception that these conditions are indicative of the system as a whole, and that all that is needed to improve the quality of housing is to create yet another expensive and redundant government bureaucracy (using what for resources I don't know) and passing more government regulations. Neither one of these is the case.

Right now, programs and services provided by BHD enable thousands of mental health consumers to live in safe, clean and affordable housing, and to thrive in their neighborhoods and at their jobs. Consumers with hopeful, positive stories to tell – and there are many – are a testament to the success of the services we offer. But they are overlooked.

I am becoming increasingly concerned, however, that this repeated unchallenged description, reinforced by editorials, sends the disturbing and wholly erroneous message that the current state of public mental healthcare is hopelessly ineffective, even harmful to its consumers. Worse yet, it subtly, even if unintentionally, reinforces the idea that maybe it's time to bring back the asylums, and with them perhaps other discredited practices like forced doping, locked wards and leather restraints.

If *re*-institutionalization is the agenda – and there are many who believe that is the solution – then we need to muster the courage to say that and let the debate on its merits begin.

It is reasonable but insufficient to argue that the conditions described in the articles depict the legacy of deinstitutionalization. Those conditions also show the force of poverty at work, and it is, in my view, important to educate the public on how these forces interact, and to prompt a public discussion on how best to address the current system's deficiencies in this context.

This is the debate that should rivet the public's attention, and this is where the power of the press can be used to its most beneficial end. Unfortunately, stories that persistently focus on one aspect of a complex, multi-dimensional problem and then indict a single government bureaucracy for failing to solve in three months an array of problems many generations old does little to enhance public understanding of the many needs and challenges faced by people with mental illness, and nothing to guide a thoughtful public debate that focuses on the real issues, and that yields informed and well-reasoned solutions.

The Milwaukee County Behavioral Health Division will do what we are charged by law to do to the best of our ability within the resources allocated to us. We expect, and I insist, that we be held accountable for our stewardship. We will continue to serve the needs of the community for mental health services with dedication and compassion. We will continue to work with community groups, advocates, service providers, housing developers, landlords, law enforcement, clinics, healthcare facilities

and caring individuals to improve how we serve our consumers. They and the taxpayers deserve no less.

But know this: No matter what we do or how hard we try, until the root systemic social and cultural viruses are eradicated, we will always be able to find another human being like Georgia Rawlings or Bessie Johnson teetering on the edge. What's worse, for every Georgia and Bessie whose misery is brought to light, there will in all likelihood be dozens, perhaps hundreds more who will remain hidden from view, who will live – if you can call it that – and die in privation as bad or worse than theirs. I'll guarantee it, though I wish desperately that I could disavow it instead.

As a bureaucrat who has invested his professional life in public service on the fundamental belief that government can be a force for good in people's lives, I confess that the prospect of facing repeated blame for tragedies I and my agency are single-handedly powerless to prevent is tremendously discouraging. The only thing more discouraging is knowing that the suffering of vulnerable victims will also continue unabated.

I'm lucky. I can walk away from this anguish; those poor souls can't. And as long as that's true, our work goes on. I am privileged to be part of that effort, even if it is "not nearly enough."

I thank the Committee once again for your patience and attention. We look forward to the opportunity to return again with an even better progress report. I will be happy to answer any questions.